CSU-2017-ROT-000057

THE OFFICE OF THE CORONER
AT TAUPO
(In Chambers)

IN THE MATTER of the Coroners Act 2006

AND

IN THE MATTER of an Inquiry into the death of RACHAEL LOUISE De JONG

Before: Coroner Wallace Bain

Date of Findings: 5 September, 2018

FINDINGS OF CORONER WALLACE BAIN (IN CHAMBERS)

I record I opened an inquiry. I decided pursuant to section 80(b) of the Coroners Act 2006 not to hold an inquest for the purposes of my inquiry because the death was not one in official custody and care, and I have also complied with the requirements of section 77 of the Coroners Act 2006 and have received no notification from any person of an intention to give evidence in person.

INTRODUCTION

[1] At about 11:00am on 6 February 2017, Rachael De Jong has gone with six other people to the Aratiatia Dam, near Taupo. They were swimming in the Waikato River when the dam flood gates were opened at the scheduled time of 12:00pm. As the rapids approached, some of the group on a small rock were swept downstream. Rachael tried to assist a friend but was swept downstream and she drowned. Her body was later recovered.

ISSUES

[2] How was it that this group came to be swimming in the Waikato River when the dam flood gates were opened immediately above them? What can be done to ensure that this tragic accident is never repeated at this venue?

[3] I have considered all available evidence including:

- Police reports to the Coroner
- ESR Toxicology Report
- Post-mortem report
- Large number of witness Statements
- Detailed WorkSafe New Zealand Report
- An Investigation Report
- Department of Conservation Report
- Mercury Energy Internal Review
- Other forensic material and Depositions

[4] I am satisfied that all the elements of the "first purpose" of an inquiry set out in section 57 (2) Coroners Act 2006 have been established.

[5] I am satisfied that the requirements of section 77 (hearings on papers and chambers findings) have been satisfied without holding an inquest. In particular, I am satisfied that persons from whom evidence is generally to be heard for the purposes of an inquiry do not wish to give evidence in person for the purposes of the inquiry. I am also satisfied that notice has been given of my proposal to make a hearing on the papers and make chambers findings to member of the immediate family of the deceased, who concur in the inquiry being concluded on the papers by way of chambers findings.

PURPOSE OF AN INQUIRY

[6] The purpose of an inquiry is set out under Part 3 of the Coroners Act 2006 (Act). Section 57 of the Act defines the purpose of inquiries as follows;

i) A coroner opens and conducts an inquiry (including any related Inquest) for the 3 purposes, and not to determine civil, criminal, or disciplinary liability.

ii) The first purpose is to establish, so far as is possible-

That a person has died; and
The person's identity;
When and where the person died; and
The causes of the death; and
The circumstances of the death.

iii) The second purpose is to make specified recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

iv) The third purpose is to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.

ACKNOWLEDGING RACHAEL

[7] At the outset of these Findings, the Court wishes to acknowledge Rachael and the tragedy of her death. Rachael's father, Kevin De Jong, made detailed written submissions to the Court which has addressed a wide range of issues and were very helpful. He emphasises there some beautiful aspects concerning his daughter Rachael. He states "Rachael was a very much loved and integral part of our family and was at home until her accident. One of her goals was to finish university with no student debt...she had worked in various jobs to find her own way through university. She was a high achieving student, through focus study and revision, which led to her tutor selecting her for a coveted research project. Her abilities in athletics was also something she prided herself in and this too was enhanced by her focus on training and desire to excel". He goes on to point out how much she is missed by the family and her many friends and that in excess of a thousand people attended her funeral. It is clear she was an intelligent young woman and from a safe position she then put her own life at risk to save her friend.

[8] Rachel's uncle, Mr Matt Wenham, on behalf of the family wrote a beautiful tribute for the New Zealand Herald. He describes her as living life in a regal sense and that..."at 21 she was the princess destined to be queen and her subjects were her family and friends and all that met her. She was bright, she was effervescent and always had a stunning smile and brought joy to all those around her. She was kind and caring and had a selflessness that attracted people to her like bees to their queen".

Clearly, Rachael's life has been a devastating loss for her family and friends and their lives will have forever changed. It is hoped by the Court that these Findings will help to prevent another tragedy and as Kevin De Jong states, create a "leadership role" to ensure that everything practical is put in place and maintained to ensure any further incidents are minimised.

MATERIAL FACTS

[9] At about 11:00am on 6 February 2017, a group comprising of two men and five women were swimming in the Waikato River. Dam flood gates were controlled by Mercury NZ Limited and at the scheduled time of 12:00pm, the gates were opened. In summary, one of the group retreated to where the group's possessions were and another person was situated on a large rock. The other five were on a small rock in the centre of the waterflow. As the rapids approached, some of the group on the small rock were swept downstream while trying to retrieve to safety.

[10] Mercury advise that the Aratiatia Rapids form the station spillway. That is a critical safety element for the power station and is used to bypass water around the station if it cannot generate for any reason. That includes maintenance outages and other factors. The station does not need to be manned for a spill to occur. The tourist spills are required by Mercury Resource Consent and allow tourists to see the riverbed fill and the flow recede, which is in contrast to the Huka Falls where tourists see a continual flow. Access to the water course is within certain areas and is prohibited in parts and overseen by the harbour master. Access to the swimming holes was gained by the swimmers by an unofficial track down to the rapids.

[11] It seems that the rapids are a popular tourist attraction and the dam gates are opened four times daily in the summer as a "tourist spill". The evidence shows that moments before the incident, the group located at the swimming hole and five members of the group took a selfie using a go-pro-stick whilst standing on a small rock.

[12] The evidence clearly shows that as the rapids started to rise, Rachael De Jong jumped in to assist a person who was located on a large rock and assisted that person to safety. She and another person were swept downstream. Tragically, Rachael drowned and her body was subsequently recovered downstream. There is a video and there are detailed photographs and the WorkSafe investigation report. They show the swimming area prior to the flood gates being opened, as being very still and somewhat idyllic area to be swimming. However, once the flood gates are opened, the contrast with the rapid water almost as surfing waves is extraordinary. Clearly the photos show that there is a rapid increase in the level of the water and its turbulence but then shortly thereafter, it reverts to the idyllic looking swimming hole that presented this group when they first arrived.

[13] There are clearly some issues about access to the swimming hole and whether the official or unofficial track can be used. The report says that five members of the group were aware of rapids being released and five heard or were aware of the siren that informs the public that the flood gates were about to open. Two of the group noted not seeing any signage and another four do not refer to any signage in their statements. The warning sirens can apparently be heard at intervals of eight minutes, five minutes and two minutes immediately prior to release and start of the gate rising. Tests on the spillway gates show that they were operating

functionally. It is reported that warning signage was upgraded in 2011 and it is checked on a weekly basis as part of the operator's rounds. Damaged and defective signs are replaced. A number of previous incidents have been catalogued.

[14] A number of preventive measures and changes have occurred since this tragic incident. Mercury have met with DOC and have installed additional signage and a wooden barrier at the unofficial track. DOC has removed rope from the set terrain that may have assisted the group getting down to the swimming hole. Inspectors have walked the official track used by the public and observed no other unofficial tracks down to the swimming hole. The WorkSafe report shows that members of the group were aware of the flood gates opening and it appears there may have been an error of judgement to remain in the water as the rapids approached rocks. In qualifying that, it seems from the evidence that whilst they were aware the dam gates were going to open, they had never seen it and clearly were unaware of what they were about to experience. That probably is the nub of the incident. It is clear from the statements and the inquiries made by the police that there is no issue of drinking or any other factors other than this group just wanted to have a swim on a hot day on their way home.

[15] From a review of the statements taken by the police from the swimming group, it seems that while there is an awareness by some of a warning from the siren, they were not clear as to whether it meant not to get in the water or precisely what would then later unfold. A number said they did not see in this track they were going on any particular signs, even any warnings. That would be because this was not a designated track to the swimming hole and it has now been closed off completely following this tragic incident. There is now new signage and a substantial fence to stop access to this other track.

[16] In his submissions, Mr Kevin De Jong makes it clear that he is not trying to apportion blame in the comments he makes but he is simply trying to help prevent another tragedy. He felt none of the interests with the organisations involved had a leadership role to ensure everything practical was put in place. In regard to that, it does seem that following this tragedy, significant steps have been taken. He notes that this spillway and its surroundings are truly beautiful spots and the swimming hole is magnificently very inviting to locals and visitors. In that regard, he feels danger messages and prevention messages need to be appropriate. At the time of the incident, there was no signage in the local's carpark or track down to the local swimming hole. The track was well worn and had ropes which would indicate to people that it was a way down to the swimming hole. The swimming hole itself and the surrounding areas had no signage and it seemed clear from reviewing matters that the five girls involved at least, did not have any idea of the danger they were in until it was too late. Since the accident, he has reviewed matters and feels the signage could be more obvious. He raises a number of issues relating to Resource Consents, signage and barriers.

WORKSAFE AND RELATED MATTERS

[17] WorkSafe New Zealand investigation report states that Mercury Energy control the Aratiatia Dam. The Department of Conservation (DOC) administers the Aratiatia rapids scenic reserve, which is Crown land adjacent to the Waikato River. The Waikato Regional Council grant the consent to operate and as part of the consent require Mercury Energy to carry out tourist spills.

[18] The spills are known as "tourist spills" and they are required under Mercury Energy Resource Consent granted by WRC to preserve the river flow.

[19] Access to the water course within certain areas is prohibited under the WRC's navigation safety bylaw. That is overseen by the WRC's harbour master. DOC administers the Aratiatia rapids scenic reserve, which is Crown land. DOC does not administer the Aratiatia rapids or any part of the Waikato River. Access to the swimming hole was gained by the swimmers via the unofficial track down to the rapids which was adjacent to the walking track on the way to the viewing platforms.

[20] Up to 100 people plus on average come to view the flood gates opening four times per day.

[21] WorkSafe go further and say that while there are a number of parties involved, the only party identified that had a direct legal duty under the Health & Safety at Work Act 2015 to the swimmers was Mercury NZ Limited. WRC state they had no regular control over the area of water that the group was swimming in. A proposal had been considered by WRC to consider if it was appropriate to use the bylaw mechanism to regulate swimming within the area where the fatality occurred. Independent legal advice was taken and it was not considered appropriate. The navigation safety bylaw is designed to regulate boating activity within the Waikato region. The area in question is not navigable and therefore not covered by the bylaw. The existing bylaw does put in place a 200-meter exclusion zone above and below the hydro dam structures however, the purpose of such zones is to remove conflicts with maintenance vessels and the harbour master vets the area. DOC have advised they do not own, manage or administer the Waikato River. DOC has no ability to influence or control the operation of the Aratiatia Hydro-electricity Station or the Aratiatia rapids. DOC administers the Aratiatia rapids scenic reserve which is adjacent to the Waikato River but is not part of the river.

[22] Since the tragedy, Mercury and senior DOC representatives have met and DOC has installed additional signage and a wooden barrier on the unofficial track with the aim of preventing that track being used. DOC also removed ropes from the steep terrain which assisted the group getting down. Mercury has a risk management programme and a six-monthly safety hazard review for each of its hydro generation site. The warning sirens are regularly checked.

[23] It is noted that under The Reserves Act 1977, Section 19(2) (a)-the public shall have freedom of entry and access to the Reserve, subject to the specific power conferred on the administering bodies by Section 55 and 56, to any bylaws under this Act applying to the Reserve, and to such conditions and restrictions as administering body considers to be necessary for the protection and well-being of the Reserve and for the

protection and control of the public using it. It is clear from the evidence and this is supported by the WorkSafe investigation that members of the group were aware of the flood gates opening and appeared to have made an error of judgement to remain in the water as the rapids approached the rock. As commented, the evidence clearly shows "...we were all aware that the dam was going to open, however most people had never seen it". There were a number of warning signs in place but because the alternative track was taken as an unofficial track, the seeing of any signage was circumvented. The sirens sounded and were audible and a number of the group heard them.

[24] Even with the siren sounding, the group had approximately six to eight minutes to get themselves to safer ground before the rapids started to rise. A group of five on the smaller rock were taking selfies moments before the rapids covered the rock. They were aware the rapids were approaching and the photo shows the rapids in the background but clearly the group had no idea of what to expect and did not appreciate the risks, which if you had not been to the area before, it is totally understandable. WorkSafe found that although Mercury had a duty to other persons under Section 36(2) of the Health & Safety at Work Act 2015 and may have had a duty under Section 30. They could not identify any failure to comply with the legislation. It was found that they had taken a number of actions to reduce the risks to persons arising from spillage of the dam but WorkSafe felt it was unreasonable to expect that their actions over the incident to have incurred liability when the unofficial track was used. DOC reported that in terms of the unofficial track, a sign with warnings had been stolen two weeks before the tragedy. It is reported that at a meeting following the tragedy between Mercury Energy and DOC the issues of prohibiting swimming at least a specified distance from the hydro structures was discussed. This was a WRC bylaw. Mercury were keen to amend the sign message from warning of the hazards to more of a 'keep out' or 'no access' message. DOC however advised they had no legal authority to prohibit people accessing public reserves but they do warn of hazards. Following that meeting the stolen signs were replaced and access affectively prohibited with a wooden barrier.

[25] The police raised the issue of the bylaw as approved by the WRC (harbour master). There was a 200-meter prohibited zone from both dam structures but this may have left a gap in the middle where the bylaw didn't apply as that appeared to be where the group had entered the spillway area. Clearly there is a need here for further consideration about activities in the area and access. The DOC signs were amended to include the bylaw message and this included a "no swimming" symbol and more regular checking of the barriers and access was to occur.

[26] The fundamental question it seems to the Court remains as this. How was it that a group of young adults, intelligent, law abiding and very successful in their own lives, were able to access the swimming area, in part read some signs but certainly hear the sirens and still swim in the area at the more dangerous time?

[27] The evidence is clear that the group had not experienced anything like this before and had no understanding at all, despite signage and warning sirens, as to what they were about to be subject to and the turbulence, force of the water and the washing machine effect on your body if you were in it.

[28] It seems to the Court that even with all the steps taken subsequent to this terrible tragedy, there is still going to be a possibility that people will visit this swimming area, swim and have no idea of what the real danger is. Consideration clearly needs to be given to prohibiting swimming in this area.

[29] The recommendation will be that the appropriate groups meet to consider whether there can be total prohibition on swimming in the area and if need be, there be legislative change.

CONCLUSIONS FROM THE EVIDENCE

(i) This was a group of seven young high achieving, sensible adults, which included amongst them an off-duty police officer.

(ii) They decided to go for a swim on a hot summer's morning.

(iii) There is no alcohol or drugs involved. The group comprised five young women and two young men.

(iv) Most had not been to the area before and it was unknown to them what to expect.

(v) They parked in a small layby which is not the normal track to the lookout. It was however, a well-used area and from that they found a well-worn walking track which, although steep, took them down to an area below the dam. The track to the swimming pool was clearly used, was a worn track and had ropes to assist.

(vi) It is a small path from the layby and it is not the recommended path for tourists to use to view the release of water from the dam. This was not an official track and the warning signage was minimal. Was the signage explicit enough at the time? Signage drew attention to a "risk of drowning", "swimming not advised", "water level may rise", "strong currents and undertows". New signage emphasises the risk of drowning and that water will rise rapidly and that it is a prohibited zone.

(vii) Perhaps the most telling comment from those involved to the police investigating the matter was "we were all aware that the dam was going to open however, most people have never seen it". It is clear to the Court that the group simply didn't realise the risks that could occur, the severe washing machine effect of the water and the severe danger of being in the water.

(viii) The warning signs simply do not make it clear enough what can be expected, particularly to people who have never seen this before. A question arises as to whether they could be more explicit?

(ix) One of the party who was familiar with the area had been told that the water release would be slow but had not seen any signs prohibiting swimming or anything to that effect. Many had never been there before and were not even sure what a dam was. Most heard the sirens but again, did not understand or fully understand what was about to occur and when.

(x) The releasing of water from the dam spillway gates is part of the consent to operate to provide tourist viewing purposes with the time stipulated.

(xi) It also seems clear to the Court that swimming in the area should be absolutely prohibited and that is simply demonstrated by the interviews given by those involved here. They are smart, intelligent young people but in essence had no idea of what to expect and on that basis were very much lulled into a false sense of security.

(xii) It is clear also there was no physical checking to see if there were any people in the area before the release of the water. That is something that modern technology with a drone may well assist in an inexpensive way.

(xiii) To their credit those involved in various activities in the area have combined and responded to the tragedy. They have closed off this unofficial track. Access has been blocked to this track from the carpark and the ropes have been removed. There is a suggestion that they are not allowed to prohibit swimming and the Court did not receive any detailed evidence in that respect. However, it is clear that the signage should be very explicit of the dangers and physically checking an area before the release of the water would be of great assistance

BRAVERY

[30] It is clear that Rachael jumped into the water to try and help one of her party but tragically got swept away. From the evidence provided to the Court, it is likely that but for this brave act, she might still be with us.

FINDING

[31] I, Wallace Bain, Coroner at Rotorua, HEREBY CERTIFY pursuant to section 94 of the Coroners Act 2006 and having considered all the information available for the purposes of the inquiry into the death of the said deceased and for the purposes of section 57 of the said Act I find:

[32] **Rachael Louise De Jong**, student, died at Taupo on 6 December 2017, her cause of death being drowning.

COMMENTS AND/OR RECOMMENDATIONS

[33] It remains to be considered whether any recommendations or comments should be made in terms of s 57(3). In so doing the Court refers to the consideration given to this section by Heron J in *Matthews v Hunter* [1993] 2 NZLR 683. Any recommendations or comments, in terms of the section are to be for the avoidance of circumstances similar to those in which the death occurred. Section 51(7) of the Coroner's Act 1988 provides:

"A coroner holds an inquest for the purpose of:

Making any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or on the manner in which any persons should act in such circumstances, that, in the opinion of the coroner, may if drawn to public attention reduce the chances of the occurrence of other deaths in such circumstances."

In *R v South London Coroner ex* p Thompson (1982) 126 SJ 625 Lord Lane CJ said of coroner's inquests (emphasising the important distinction that exists between accusatorial and inquisitorial processes):

"Once again it should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest, it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the Judge holding the balance of the ring, whichever metaphor one chooses to use."
The Brodrick Committee (Report of the Committee on Death Certification and Coroners dated 22 September 1971, CMND 4810 chaired by Mr (late Judge) Norman Brodrick QC) exhaustively considered the role of the coroner's inquest in modern society and identified the following grounds of public interest which it believed a Coroner's inquiry should serve:

(i) To determine the medical cause of death.
(ii) To allay rumours or suspicion.
(iii) To draw attention to the existence of circumstances which if unremedied, might lead to further deaths.
(iv) To advance medical knowledge.
(v) To preserve the legal interests of the deceased person's family, heirs or other interested parties."

Furthermore, case law amplifies how a coroner shareholder act and in the case of *Luow v McLean* CP 445/87 Hardies boys J, cited with approval excerpts from the following case which sets out the coroner's roles:

In the case of Ex Parte Minister of Justice re ***Malcolm*** [1965] NSWR 1598 at 1602:

"they can, and should, afford a quick and cheap method of drawing public circumstances attaching to a death, even though there is no suggestion of murder of manslaughter, are one example. Thus, the relatives of a deceased person may feel that the deceased died owing to the negligence or inefficiency of medical authorities; there have been, for instance, several recent cases connected with the admission of patients to mental or other hospitals. If there has been any dereliction for duty, the facts are brought out into the open for all to judge; equally if the suspicions are unjustified, this also can be exposed and the persons cleared of unjustified suspicion. A properly conducted inquest has advantages in speed and cheapness over alternative judicial proceedings."

COMMENT

[34] This is indeed a tragic accident. The Court agrees with Rachael's father, Mr Kevin De Jong, that this Inquest is not to apportion blame as no one meant this to happen, but it is to try and help prevent another tragedy.

[35] The authorities in charge of the area have taken significant steps with signage and blocking access.

[36] In the Court's view, matters could go further with more explicit signage, consideration to trying to have swimming prohibited and making that very clear.

[37] Also, there could be a physical check of the area before water is released and the use of a drone could be considered. Mercury advises that this is being considered, but they need to look at the practicalities of it.

[38] These are comments on the basis of the evidence before the Court.

RECOMMENDATIONS

[39] Whilst the Court could make a number of detailed recommendations, it is of the view that most of those would relate to safety and they are already encompassed and the steps that have been taken, as outlined in the evidence above since this tragic accident. The basic question however is encompassed in paragraph [26].

> The fundamental question it seems to the Court remains as this. How was it that a group of young adults, intelligent, law abiding and very successful in their own lives, were able to access the swimming area, in part read some signs but certainly hear the sirens and still swim in the area at the more dangerous time?

[40] The Coroners Act directs as a major Purpose of an Inquiry as set out in paragraph [6] (iii):

> The second purpose is to make specified recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

[41] The Court is focused on what would reduce and prevent the occurrence of another death at this venue?

[42] As stated in paragraph [27] and [28] above:

> The evidence is clear that the group had not experienced anything like this before and had no understanding at all, despite signage and warning sirens, as to what they were about to be subjected to and the turbulence, force of the water and the washing machine effect on your body if you were in it.
>
> It seems to the Court that even with all the steps taken subsequent to this terrible tragedy, it is still going to be possible that people will visit this swimming area, swim and have no idea of what the real danger is. Consideration clearly needs to be given to prohibiting swimming in this area.

[43] The Court **strongly recommends**:

(i) That the appropriate groups associated with the administration of the Aratiatia Dam Rapids and surrounding scenic reserve, which appear to the Court to be Mercury Energy, Department of Conservation and the Waikato Regional Council, urgently meet to consider how to implement a total prohibition on swimming in the area whilst "tourist spills" continue.

It is noted from the submissions that this recommendation is strongly supported.

[44] It is clear to the Court, that a tragedy similar to this is likely to occur in the future despite the presence of signs and sirens and other measures. If the group that were caught on this occasion were not able to sense the imminent danger with all that was then in place, then it is clearly possible that this could occur again, especially as it is a tourist area.

[45] That consideration be given to whether legislative change is necessary to enable a total prohibition of swimming in the area.

[46] That consideration also be given to implementing a system of inspection of the area before any "tourist spills" are released. That may well involve new technology in the use of a drone.

[47] It is directed that a copy of these Findings be sent to; Minister of Conservation, Mercury Energy, Department of Conservation and the Waikato Regional Council.

ADVERSE COMMENT

[48] There is a requirement under the Coroners Act to ensure that the Coroner does not comment adversely on a dead person or a living person, without ensuring there is notification and there is a chance to respond.

[49] These Findings, in the Court's view, do not invoke the section relating to adverse comment. If it did, then the Court is of the view that more than adequate notice has been given to all people and organisations involved and they have had more than adequate opportunities to raise any concerns they have with the Court and had the opportunity to appear at an Inquest. In addition, opportunity was given to make submissions.

[50] These Findings in provisional form were released to the parties. Some further submissions have been made and considered carefully by the Court. Where considered necessary, adjustments have been made.

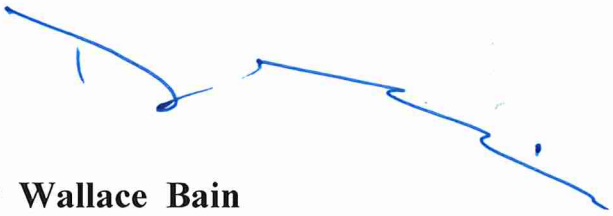
[51] The condolences of the Court are extended to the De Jong family.

[52] Pursuant to section 74 of the Coroners Act 2006, I prohibit the making public of the following:

(i) All photographs, videos, and submissions forming part of the evidence.

(ii) The addresses, telephone numbers, e-mail addresses (where applicable) of persons who have provided signed statements in evidence.

Signed by the Coroner at Rotorua this 5th day of September 2018



Coroner Wallace Bain

Regional Coroner - Bay of Plenty